UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 19

POWELL COUNTY MEMORIAL HOSPITAL

Employer-Petitioner

and Case 19--UC--687

AMERICAN FEDERATION OF STATE,
COUNTY & MUNICIPAL WORKERS

Union

CORRECTED DECISION

The Decision and Order in this matter issued on 2/7/02.

It has come to my attention that the Decision contains multiple errors, primarily by referring to "LPNs" as "Lens", and "CNAs" as "Cans".[1]

Please substitute the document previously mailed to you, entitled "Corrected Decision and Order" for the copy sent on 2/7/02. There are no changes of substance, so the exceptions due date *remains unchanged.* I regret the inconvenience.

DATED at Seattle, Washington, this 11th day of February 2002.

Paul Eggert, Regional Director
National Labor Relations Board, Region 19
2948 Jackson Federal Building
915 Second Avenue
Seattle, Washington 98174

[1] Proof that reliance on computer spell checks cannot be automatic.

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CORRECTED DECISION AND ORDER

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding,[1] the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer-Petitioner is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

The Employer is engaged in the operation of a critical care hospital, a nursing home and a clinic, all under one roof in rural Montana. The medical care staff - RNs, LPNs and CNAs - are combined in a single unit represented by the Union.

By this petition, the Petitioner/Employer seeks to remove all RNs from the Unit, as supervisors.

The petition was timely filed, and no party contends otherwise.

The entire operation is located in Deer Lodge, Montana. In 1998 the State conducted two separate elections, one among the RNs, the other among the LPNs and CNAs. The Union was certified in both units; later, the parties voluntarily combined the units ("Unit").

[1] A brief was filed by the union and duly considered. The Employer filed no brief.

The operation is relatively small. There are sixteen beds in long-term care; ("LTC") 15 beds plus another 5 "swing" beds that can be used for either acute or long-term care, in the hospital. All told, there are about 16 RNs, 19 LPNs and 29 CNAs in the Unit.

The enterprise is run by CEO Pfaff, who reports to the Board of Directors. Reporting to Pfaff are about a dozen department heads, including Director of Nursing ("DN") Harper. Reporting to Harper are, inter alia, the LTC Director. All of the afore-mentioned are excluded from the Unit.

The enterprise operates on three shifts, AM, PM and night. The DN and LTC heads are on duty during the weekday AM shift. LTC is generally staffed with two CNAs per shift, except from 10:00 pm until the start of the AM shift, when there is only one. The clinic has no RNs, but it appears it has some LPNs. The hospital is staffed routinely with two nurses, at least one of whom must be an RN. There are no CNAs assigned to the hospital.[2]

RNs have no role in hiring. They have no role in discharge, suspension or discipline, except that they can/should report conduct or performance problems to the DN. They would not recommend any action. An RN could send an obviously intoxicated employee home, and report same to the DN for the latter's disposition. RNs can verbally castigate an employee, but that action carries no particular disciplinary significance, such as being Step I of a multi-step progressive discipline system.

The RN has no ability to promote or reward. There have been no evaluations for a couple of years; before then, they were only a form of confidential peer feedback. The RN plays no role in layoff or recall, if indeed there are any. RNs do not get involved in grievance adjustments; such matters are handled by the DN. It is clear that an RN has no involvement in any transfers. She cannot take a CNA, for instance, and move her to the hospital permanently, or even for a shift.

The RN has a limited role in work assignment. If the RNs were busy and needed a hand to cover something - say, to answer a patient's call light - the RN could ask the CNA to help handle that particular task. The CNA would oblige, or present a conflicting demand from her own work. They would "work it out" normally, comparing the priorities of the conflicting demands in an informal exchange. The bottom line is that *if* the CNA refused to assist, and *if* persuasion didn't work, the RN could not and would not order the CNA to comply; all the RN could do would be to report the matter to the DN. But the evidence indicates that the reality is that such a scenario is quite remote at worst, since the employees view themselves as part of a team, and as health care professionals with the patient's needs predominating. Thus, if an emergency patient were brought to the ER, and the RN called the CNA or LPN to, for example, assist by writing down vital signs, there would assuredly be compliance.

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[2] There is testimony at p. 21 of the Transcript that would indicate that RNs work mostly in LTC, "just like" the LPNs and the CNAs. This is obviously an error either in testimony or reporting (based on a review all other testimony in the record).

The record shows a "head" of "Surgery" and one for the "Operating Room." There is no indication of any RN anywhere in the enterprise other than out on the hospital floor.

At the start of the work shift, the two nurses split up the patients, the RN generally taking the more acute ones. Where such concerns are not present, they divvy up the work by consensus, trying to split the work evenly. For example, if one had difficult patient X yesterday, then the other might volunteer to take that patient today. The CNAs split their assignments by consensus as well.

The work schedule is made out well in advance, the staffing slots determined by the DN. The employees fill in the slots they wish to work, picking shifts, work days, vacations. The precise methodology does not appear in the record, but the RNs are not involved except for filling in their own slots. The DN is responsible for making sure all shifts are covered.

From time to time, the hospital census is low, and a decision is made to reduce the number of employees needed for an upcoming shift. This decision can be made by the DN or perhaps some other management person, or by the RN. There are some guideposts for this decision: By law there must *always* be at least one RN on duty; on the night shift, by policy, normally at least two nurses, at least one an RN. If there are at least three patients, the complement of nurses will almost always be two. The question will normally arise only if there are two or less hospital patients, and then for the AM or PM shift[3]. However, the night shift RN could be calling off an employee scheduled for the upcoming AM shift, if that decision had not been made by higher authority earlier. There was testimony that an RN could decide that there wasn't sufficient census to justify the scheduled crew, and send someone home early.

Selection of the person to be called off or sent home early is by application of volunteerism. The RN would call, or delegate someone to call, among those scheduled for the next shift, and ask if they wanted to stay home. The object would be to find *a* volunteer among equals; there is no judgment involved in the selection. If no volunteers were obtained, the matter would have to be referred to the DN. The same sort of volunteerism in would be used for having someone leave early.

Similarly, there are times in mid-shift when another employee must be called in, especially on the night shift. One circumstance would be for an employee who called in with some emergency that would preclude their working a scheduled shift. Technically, each employee is expected to find their own replacement, and they usually do, but this doesn't always happen. In such case, the RN or her designee would start calling down the list, until a replacement were found. Those who had just worked or were scheduled to come on duty on the next shift would likely not be called *first*.

If cajolery, either on the scheduled employee claiming inability to work or on the entire call list, did not work, the problem would be referred to the DN.[4] The Employer under the contract could *order* the junior employee to come in. In practice, the DN very possibly will come in and work the shift. There was one incident where the list was exhausted and the DN was called. The DN instructed the RN to order a particular

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[3] On the night shift, the policy is to have two nurses scheduled, minimum. It may be that if the census is low, one of them could (would) go home early, but this is not clear from the record.

[4] In once case, the RN could find no volunteer, and the DN was out of town. In that circumstance it appears the RN pressed the offending employee to respond to her sense of duty or fair play, and work. The record shows the employee worked, without an express order.

employee to work. Even then the RN resisted, claiming it should not be, or wasn't, her responsibility, although it appears she did make the call. Her complaint about being forced to assume the calling responsibility persisted even after the assignment. The record does not show whether or how this issue was resolved for future purposes. It must be noted that the RN was not told she should handle the entire situation, either this or the next time; or that she should select the person to be directed to work; rather, only that the RN was directed by the DN to call the employee and pass on the DN's decision to order the employee in.

Another circumstance requiring a mid-shift call-in would be a mid-shift increase in census, such as a traffic accident bringing a serious injury, or multiple injuries, to the ER. In such circumstances, the RN would direct someone to start calling - possibly the CNA - while the RN started preparation or treatment in the ER, perhaps with the assistance of the LPN.[5] Again, the call would go to the first reachable, available body in the nurse pool. There is no showing that the RN could or would order someone in, but again, it appears that someone is normally, almost universally, found.[6] Undoubtedly the team concept and the patient's needs at stake would enhance agreeability. Under such circumstances, issues of overtime would not be considered; if someone were called that were so entitled, that would be dealt with later in a form report to the DN[7]. Presumably, the DN would be in a position to send the person home, or juggle their shift, to preclude overtime, or just to absorb the cost.

In all of the foregoing, there is some degree of judgment in whether to send someone home, or to call in someone. In most circumstances, the answer is fairly obvious: There must be at least one RN on duty, two at night. If there are at least three patients, normally that will mean two nurses under any circumstances. If there is a significant emergency, call in another person. There is no judgment involved in the selection of the individual - one nurse is as good as another. There is no authority to force an individual to leave or to come in. There may be some overtime involved, there may not; it is not (generally) a real consideration.

I conclude that the foregoing do not demonstrate the statutory authority to "assign" work or to "transfer". Sending employees home early or calling them in, particularly when not backed with authority to enforce, is not a statutory indicium nor is it work "assignment", especially when there is no authority to convert a request into an order.

The only statutory indicium left to consider is "responsibly direct" employees, utilizing "independent judgment". In connection with this factor, I will consider all of the RN's duties and responsibilities. This includes items that arguably fell under one of the

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[5] There was some testimony that *anyone* could elect to call in an employee under such circumstances. This appeared to be a (somewhat disingenuous) failure to distinguish between who made the decision to call *someone*, and who did the actual phoning. The evidence is clear that the RN would make the decision, or agree to a suggestion or offer to do so, not that a CNA totally sua sponte could start phoning without some signal from the RN.

[6] It must be emphasized that this is a small, rural hospital; we are not talking about the ER in a major trauma center with a continuous stream of victims.

[7] There was evidence that on one occasion the RN felt compelled to clear with the DN bringing in the available employee, because the latter would be accruing overtime.

other indicia, but did not actually meet the tests of independence of judgment or the test of significance of judgment. For example, an individual might not "assign" work in the statutory sense, but still be responsible for, say, assigning work by following some standardized principles or instructions from the employer. "Responsibly direct" must mean something apart from the other indicia, or Congress would not have included it as a separate indicium. Thus, I will, in assessing whether there is responsible discretion, consider all of the duties and responsibilities and all of the authority of the RNs, even though they do not meet any of the other indicia.

There is no evidence that RN's are expected or required to act as some sort of quality control inspector of the other employees' work, or that they do this as a regular part of their work. There is no indication that the RN normally ventures over to the LTC side, except perhaps if a CNA reports a patient problem.[8] There is some very brief allusion to a recent internal "survey" and the need for someone to check on CNAs and make sure things are getting done, but there is no hint that any steps have been take in that regard, or that it would be the RN that would handle that function, rather than the Director of LTC.

There is no evidence that employees have ever been told that the RN(s) are in charge, or that they must follow their instructions or requests. When two RNs are on duty, one of them is never designated formally or by understanding as "in charge". On the other hand, it must be conceded that RNs are the most experienced/trained individuals on duty, on the PM or nightshifts.[9] They perform the more difficult work, they decide if a patient's physician must be called and, they decide if, in an emergency context, the DN should be called or brought in.

There is no evidence that RNs have been told they are responsible for the work of the other employees on their shift, that is, that a mistake by one of the latter is deemed a mistake or fault of the RN, or that it is part of the RN's job to make sure the others perform their own jobs satisfactorily. The RNs are not paid a bonus for successful work on their shifts, nor is there any evidence any RN has ever been disciplined or reprimanded for anything that went awry on their shift. There is some vague testimony that an RN could be held responsible if some sort of malpractice incident that seriously harmed a patient took place on her shift, especially if it evolved into a lawsuit. However, there is no example that such an event has ever happened, how the RN is or was held "responsible", or that RNs are told in advance that such is their risk.

RNs currently do not do any formal evaluations of fellow employees. In the past they were performed, but only as part of confidential peer evaluations which carried no weight for any employee reward or discipline.

Based on the entire record, but particularly the above discussion of "responsibly direct", I conclude that the RNs do not responsibly direct employees, while utilizing a substantial degree of independent judgment, as those terms are used in the Act. The

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[8] CNAs are in LTC. This section serves the same patients for extended periods, with routinized daily work responsibilities. There is minimal variation from day to day.

[9] During the AM shift, the DN and the Director of the LTC are on duty, at least during the week.

"responsibly" element and the "direct" elements are missing. Employees are not told that the RNs are their boss and in charge, nor does it appears that the RNs are, either. There is no indication that the RNs are held *responsible* for all that goes on during their shift. There is no indication they have real authority to *direct* anyone to do anything, under penalty of discipline. The employees don't view the RNs as having this authority, nor do the RNs themselves.

The RNs are not responsible for monitoring quality control, or writing performance evaluations, or setting schedules, or assigning patients, or any of a score of other possible functions a person "in charge" might perform.

The RNs do step to the front when emergencies arise, but of course they are the most skilled person on site (unless there is another RN working with them or the DN is on site). This is not a facility with a steady stream of "emergencies"[10] - note that there is no RN assigned to the ER, nor is there a physician on site. When a serious emergency arises, the RN calls a physician and/or the DN, who would take charge by phone or in person, if the DN is not already on site. The RN could call in additional help, if necessary. While the RN is treating an emergency patient she may tell one employee to start the calling procedure for extra help, and tell another to assist her in treatment, such as by taking vital signs or making notes, but this would last only until the RN got instructions from someone with greater professional training, such as the physician, or perhaps the DN. At that point she would be more in the position of relaying instructions, rather than being in charge. Still, the RN would lack true authority over anyone to do anything.

Accordingly, I conclude that the record does not demonstrate responsible direction of the workforce involved herein. Since it has not been demonstrated that the RNs possess any of the statutory indicia, they are not supervisors as defined in the Act. Accordingly, the UC petition to remove them from the Unit must be denied.[11]

ORDER

IT IS HEREBY ORDERED that the petition filed herein be, and it hereby is, dismissed.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street N.W., Washington, D.C. 20570. This request must be received by the Board in Washington by February 21, 2002.

DATED at Seattle, Washington, this 11th day of February 2002.

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[10] The record reflects that "emergencies" are handled, but not the types or severity. For example, it appears unlikely that major trauma cases are handled here, judging from the record. The record does not reflect the frequency of emergencies.

[11] The burden is in the party alleging supervisory status to establish same. *Kentucky River Community Care*, 121 S.Ct. 2164 (2001).

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